U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 07 September 2005

Case No. : 2004-BLA-5705

In the Matter of:

DARRELL RAY CURTIS,
Claimant

v.

PEABODY COAL COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:[1]

Ronald K. Bruce, Esq.
For the Claimant

Philip J. Reverman, Jr., Esq.
For the Employer

BEFORE: Robert L. Hillyard
Administrative Law Judge

DECISION AND ORDER - DENIAL OF BENEFITS

This proceeding arises from a claim filed by Darrell R. Curtis for benefits under the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901, *et seq.*, as amended ("Act"). In accordance with the Act, and the regulations issued thereunder, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs, for a formal hearing.

Benefits under the Act are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of persons who were

[1] The Director, OWCP, was not represented at the hearing.

totally disabled at the time of their death or whose death was caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lungs arising out of coal mine employment commonly known as black lung.

A formal hearing in this case was held in Madisonville, Kentucky, on March 8, 2005. Each party was afforded full opportunity to present evidence and argument at the hearing as provided in the Act and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.

The findings and conclusions that follow are based upon my observation of the appearance and the demeanor of the witness who testified at the hearing, and upon a careful analysis of the entire record in light of the arguments of the parties, applicable statutory provisions, regulations, and pertinent case law.

I. Statement of the Case

The Claimant, Darrell Ray Curtis, filed a claim for black lung benefits under the provisions of Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, on September 6, 2002 (DX 2).[2] A Notice of Claim was issued on September 27, 2002, identifying Peabody Coal Company as the responsible operator (DX 10). On November 8, 2002, the Employer filed its Response to Notice of Claim (DX 11), and on November 19, 2002, the Employer filed its Controversion (DX 12). The District Director, OWCP, awarded benefits on October 16, 2003 (DX 17). The Employer requested a formal hearing and the claim was referred to the Office of Administrative Law Judges on February 3, 2004 (DX 22). A hearing was held in Madisonville, Kentucky, on March 8, 2005, before the undersigned Administrative Law Judge. The record was held open for 30 days for the submission of deposition testimony from Drs. Repsher and Houser and for the submission of a rebuttal x-ray interpretation by Dr. Wiot (Tr. 7, 25), and for an additional 30 days for the submission of briefs (Tr. 26).

II. Issues[3]

The issues as listed on Form CM-1025 are:

1. Whether the Miner has pneumoconiosis as defined by the Act and the regulations;

2. Whether the Miner's pneumoconiosis arose out of coal mine employment;

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[2] In this Decision, "DX" refers to the Director's Exhibits, "CX" refers to the Claimant's Exhibits, "EX" refers to the Employer's Exhibits, and "Tr." refers to the transcript of the hearing.

[3] At the hearing, the Employer withdrew the issues of timeliness, responsible operator, insurance, and total disability (Tr.10).

3. Whether the Miner's disability is due to pneumoconiosis; and,

4. The remaining issues set forth in paragraph 18, as well as the issues as to constitutionality of the Act and its regulations are preserved for appeal purposes.

III. Findings of Fact and Conclusions of Law

The Claimant, Darrell R. Curtis, was born on November 14, 1938 (DX 2). He is a high school graduate (DX 2; Tr. 11). The Claimant has one dependent for purposes of augmentation of benefits; namely his wife, Sherry, whom he married on March 27, 1971 (DX 6; Tr. 11).

The Claimant testified that he has smoked off and on since the late 1960's at a rate of up to two packs per day (Tr. 18). The physician's records support the testimony regarding a smoking start date (*See, e.g.*, DX 16; CX 3, 4). The physician's reports do not support the testimony that he smoked off and on. Based on the smoking histories contained in the medical reports and the Claimant's testimony, I find that the Claimant has a smoking history of 35+ years at a rate of up to two packs per day of cigarettes.

Coal Mine Employment

Section 725.101(a)(32)(ii) directs an adjudication officer to determine the beginning and ending dates of coal mine employment using any credible evidence. On his application, the Claimant stated that he worked in coal mine employment for 25 years (DX 2). Length of coal mine employment is not contested.

The Claimant's Employment History form lists coal mine employment from 1967-1995 (DX 3). The Claimant's FICA Earnings worksheet shows employment from 1978-1987 and from 1993-1995 (DX 5).[4] An employment verification from Peabody Coal Company lists employment by the Claimant from 1971-1986 and from 1992-1995 (DX 13). Based on the above, I find that the Claimant has established 25 years of coal mine employment. On his Employment History, the Claimant stated that over the relevant period, he was a coal truck driver (DX 3; Tr. 12).

The Claimant's last employment was in the Commonwealth of Kentucky; therefore, the law of the Sixth Circuit is controlling.

[4] FICA Earnings records were only stated from 1978-2001.

Responsible Operator

The Employer has withdrawn it's challenge to the issue of responsible operator, and I find that Peabody Coal Company is properly named as the responsible operator pursuant to §§ 725.494 and 725.495 (Tr. 10).

IV. Medical Evidence

X-ray Studies

	Date	Exh.	Doctor	Reading	Standard
1.	01/31/05	EX 3	Wiot B reader[5] Board cert.[6]	Negative	Good
2.	01/31/05	CX 4	Baker B reader	1/2	Good
3.	06/30/04	EX 6	Wiot B reader Board cert.	Negative	Fair/ overexposed
4.	06/24/03	DX 16	O'Bryan B reader	0/1	Good
5.	06/24/03	EX 3	Wiot B reader Board cert.	Negative	Good
6.	06/24/03	CX 2	Brandon B reader Board cert.	2/1 q/q	Fair/ overexposed
7.	02/13/03	DX 9	Barrett B reader Board cert.	Quality only	Good

[5] A "B reader" is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successfully completing an examination conducted by or on behalf of the Department of Health and Human Services. *See* 42 C.F.R. § 37.51(b)(2).

[6] A Board-certified Radiologist is a physician who is certified in Radiology or Diagnostic Roentgenology by the American Board of Radiology or the American Osteopathic Association. *See* § 718.202(a)(ii)(C).

8.	02/13/03	DX 8	Simpao	1/0, p/p	Good
9.	02/13/03	CX 1	Brandon B reader Board cert.	1/2 , q/q	Fair
10.	02/13/03	EX 1	Spitz B reader Board cert.	Negative	Good

Pulmonary Function Studies

	Date	Exh.	Doctor	Age/Hgt.[7]	FEV_1	MVV	FVC	FEV_1/ FVC	Standards
1.	01/31/05	CX 4	Baker	66/64¾"	1.48	52	2.84	52.1%	Tracings included. Good coop./ comp.
2.	07/19/04	CX 3	Houser	65/66" Post-Bronch.	1.26 1.44	43.4 60.6	2.22 2.46	57% 59%	Tracings included. Good coop./ comp.
3.	06/24/03	DX 16	O'Bryan	64/65½ " Post-Bronch.	1.18 1.25	54 61	2.14 2.34	55.1% 53.4%	Tracings included. Good coop./ coop.
4.	02/13/03	DX 9	Simpao	64/65"	1.44	53	2.60	55.4%	Tracings included. Good coop./ comp.

Validation: Dr. Burki opined that this test was valid (DX 9).

[7] The factfinder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). At the hearing, the Miner testified that he was "about five-six" (Tr. 22). Based on his testimony, I find the Miner's height to be 65½".

Arterial Blood Gas Studies

	Date	Exhibit	Physician	pCO_2	pO_2
1.	06/24/03	DX 16	O'Bryan	41.7	52.8
			After exercise	39.9	84.6
2.	02/13/03	DX 9	Simpao	48.6	63.5

Narrative Medical Evidence

1. Dr. William O'Bryan, a Board-certified Internist, Pulmonologist, and B reader, examined the Claimant on June 24, 2003, at which time he noted symptoms (sputum, dyspnea, cough, chest pain, ankle edema), employment history (28 yrs. surface), individual and family histories (arthritis, diabetes, high blood pressure), smoking history (35 yrs., 1-2 ppd), and performed a physical examination (lungs over-inflated, rhonchi, obese (65½", 248 lbs.), chest x-ray (0/1), pulmonary function study (severe obstruction, lung volumes abnormal), and an arterial blood gas study (hypoxic at rest) (DX 16). Dr. O'Bryan diagnosed no clinical or legal pneumoconiosis, suspected sleep disorder, and severe obstructive lung disease. He opined that the Miner's impairment was due to a combination of cigarette smoking and obesity. He opined that the Miner's severe obstructive lung disease would prohibit the Claimant from returning to his previous coal mine position.

2. Dr. Glen Baker, a Board-certified Internist, Pulmonologist, and B reader, examined the Claimant on January 31, 2005, at which time he noted symptoms (sputum, wheezing, dyspnea, cough, orthopnea, ankle edema), employment history (23.5 yrs. surface mining), individual and family histories (pneumonia, pleurisy, arthritis, diabetes), smoking history (started late 1960's-early 1970's, 2 ppd), and performed a physical examination (normal), chest x-ray (1/2), and a pulmonary function study (moderate obstructive defect) (CX 4). Dr. Baker diagnosed coal workers' pneumoconiosis based on abnormal chest x-ray and a history of coal dust exposure; COPD, caused by smoking and coal dust exposure, based on pulmonary function testing; and bronchitis, caused in part by coal dust exposure, based on history. He opined that the Miner's impairment was caused primarily by cigarette smoking, and he stated that based on 23 years of coal dust exposure, reported symptoms, and a positive x-ray, it was his opinion that coal dust-related complications "may" be acting in synergy with cigarette-induced conditions. He opined that the Miner no longer retains the respiratory capacity to perform the work of a coal miner. He based his disability determination on pulmonary function testing showing FEV_1 readings between 40 and 59% of predicted.[8]

[8] Dr. Baker utilized Table 5-12, Page 107, Chapter Five, *Guides to the Evaluation of Permanent Impairment*, Fifth Edition, to assist in his disability opinion.

3. a. Dr. William C. Houser, a Board-certified Pulmonologist, Critical Care Specialist, and B reader, treated the Miner several times during 2004, and he submitted treatment records and a letter on the Claimant's behalf (CX 3). Treatment notes list symptoms (cough, sputum, dyspnea, some wheezing), employment history (27 yrs. coal mine employment), individual and family histories (pneumonia, arthritis, hypertension, diabetes, sleep apnea), smoking history (31+ years, 1½-2 packs per day), physical examination findings (few rales, diminished breath sounds, prolonged expiratory phase, obesity 246 lbs.), chest x-ray (1/1), and a pulmonary function study (moderately severe obstruction) (CX 3). He diagnosed coal workers' pneumoconiosis based on an abnormal x-ray. He diagnosed COPD, caused in part by coal dust exposure, and opined that the Miner is physically unable to perform his former job as a coal miner.

b. Dr. Houser was deposed by the Employer on March 14, 2005, when he repeated the findings of his earlier written report (EX 4).

4. a. Dr. Lawrence Repsher, a Board-certified Internist, Pulmonologist, and B reader, submitted a consultative report on behalf of the Employer (EX 2). Dr. Repsher noted 27½ years of coal mine employment and a smoking history of up to two packs per day from 1968 to the present. Past medical history included knee surgery, right carotid endarterectomy, morbid obesity, hypertension, and sleep apnea. Dr. Repsher opined that the objective evidence showed no evidence of clinical or legal pneumoconiosis. He based his opinion on negative x-ray evidence (as read by Dr. Spitz), pulmonary function testing showing pure obstruction due to a long, continued, and very heavy cigarette smoking habit, no histologic evidence of pneumoconiosis, and no arterial blood gas evidence of pneumoconiosis. He discussed extensive medical literature which he opined demonstrated that "in any individual coal miner, to an overwhelming probability, any detectable COPD would be the result of cigarette smoking and/or asthma, but not the result of coal mine dust."

b. Dr. Repsher was deposed by the Employer on March 25, 2005, during which he repeated the findings in his earlier consultation report (EX 5).

5. Dr. Simpao, who lists no medical specialty credentials, examined the Claimant on February 13, 2003, at which time he noted symptoms (sputum, wheezing, dyspnea, cough, chest pain), employment history (25 yrs. surface mining), individual and family histories (pleurisy, arthritis, high blood pressure, knee replacement, carotidendarectomy), smoking history (37 yrs./2 ppd), and performed a physical examination (increased resonance upper chest and aux. areas, few crepitations, occ. forced exp. wheezes), chest x-ray (1/0), pulmonary function study (moderate restriction, severe obstruction), arterial blood gas study (ventilatory perfusion mismatch/mild hypoxia), and an EKG (abnormal) (DX 9). Dr. Simpao diagnosed coal workers' pneumoconiosis and opined that the Miner suffers from a moderate

impairment that would prevent him from performing the work of a coal miner. He based his opinion on an abnormal chest x-ray, EKG, arterial blood gas and pulmonary function testing, along with physical findings on examination and symptoms.

V. Discussion and Applicable Law

The Claimant filed his black lung benefits claim on September 6, 2002 (DX 2). Because this claim was filed after March 31, 1980, the effective date of Part 718, it must be adjudicated under those regulations.[9]

In order to establish entitlement to benefits in a living miner's claim, pursuant to 20 C.F.R. § 718, the claimant must establish that he suffers from pneumoconiosis, that the pneumoconiosis arose out of coal mine employment, and that the pneumoconiosis is totally disabling. *See* 20 C.F.R. §§ 718.3, 718.202, 718.203, 718.204; *Peabody Coal Co. v. Hill*, 123 F.3d 412, 21 B.L.R. 2-192 (6th Cir. 1997); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987). Failure to establish any of these elements precludes entitlement. *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986) (*en banc*).

Section 718.202 provides four means by which pneumoconiosis may be established. Under § 718.202(a)(1), a finding of pneumoconiosis may be made on the basis of x-ray evidence. The record contains nine interpretations of four different chest x-rays. Dr. Barrett reviewed the February 13, 2003, x-ray film for quality purposes only and rated the film as good.

The Board has held that an Administrative Law Judge is not required to defer to the numerical superiority of x-ray evidence, *Wilt v. Wolverine Mining Co.*, 14 B.L.R. 1-65 (1990), although it is within his or her discretion to do so, *Edmiston v. F&R Coal Co.*, 14 B.L.R. 1-65 (1990). However, "administrative factfinders simply cannot consider the quantity of evidence alone, without reference to a difference in the qualifications of the readers or without an examination of the party affiliation of the experts." *Woodward v. Director, OWCP*, 991 F.2d 314 (6th Cir. 1993).

Interpretations of B readers are entitled to greater weight because of their expertise and proficiency in classifying x-rays. *Vance v. Eastern Assoc. Coal Corp., Aimone v. Morrison Knudson Co.*, 8 B.L.R. 1-32 (1985); 8 B.L.R. 1-68 (1985). Physicians who are Board-certified Radiologists as well as B readers may be accorded still greater weight. *Woodward v. Director, OWCP*, 991 F.2d 314, 316 n.4 (6th Cir. 1993); *Zeigler Coal Co. v. Kelley*, 112 F.3d 839, 842-43 (7th Cir. 1997); *Bethenergy Mines, Inc. v. Cunningham*, Case No. 03-1561 (4th Cir., July 20, 2004) (unpub.).

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[9] Amendments to the Part 718 regulations became effective on January 19, 2001. Section 718.2 provides that the provisions of § 718 shall, to the extent appropriate, be construed together in the adjudication of all claims.

The January 31, 2005, x-ray was read as negative by Dr. Wiot, a Board-certified Radiologist and B reader, and as positive by Dr. Baker, a B reader. I give greater weight to the dually certified reading of Dr. Wiot and find that the January 31, 2005, x-ray evidence is negative for pneumoconiosis.

The June 30, 2004, x-ray was read as negative by Dr. Wiot.

The June 24, 2003, x-ray was read as negative by Dr. Wiot, a dually certified physician, as negative by Dr. O'Bryan, a B reader, and as positive by Dr. Brandon, a dually certified physician. I give greater weight to the majority negative readings by Drs. Wiot and O'Bryan and find that the June 24, 2003, x-ray evidence is negative for pneumoconiosis.

The February 13, 2003, x-ray was read as positive by Dr. Brandon, a dually certified physician, as positive by Dr. Simpao, who lists no radiographic credentials, and as negative by Dr. Spitz, a Board-certified Radiologist and B reader. Noting Dr. Simpao's lack of x-ray credentials, I give his interpretation little weight. Noting one positive and one negative reading by dually certified physicians, I find that the February 13, 2003, x-ray is inconclusive for pneumoconiosis.

The record contains three negative x-rays and one inconclusive x-ray film. A review of readings by dually certified physicians shows four negative readings and two positive readings. Taken as a whole, I find that the existence of pneumoconiosis has not been established by a preponderance of the evidence under 20 C.F.R. § 718.202(a)(1).

Section 718.202(a)(2) is inapplicable because there are no biopsy or autopsy results. Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of the several presumptions are found to be applicable. In the instant case, § 718.304 does not apply because there is no x-ray, biopsy, autopsy, or other evidence of large opacities or massive lesions in the lungs. Section 718.305 is not applicable to claims filed after January 1, 1982. Section 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982.

Under § 718.202(a)(4), a determination of the existence of pneumoconiosis may be made if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. Pneumoconiosis is defined in § 718.201 as a chronic dust disease of the lung, including respiratory or pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis.

> (1) *Clinical Pneumoconiosis*. 'Clinical pneumoconiosis' consists of those diseases recognized by the medical community as pneumoconiosis, i.e.,

> conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) *Legal Pneumoconiosis*. 'Legal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

Section 718.201(a).

For a physician's opinion to be accorded probative value, it must be well reasoned and based upon objective medical evidence. A reasoned opinion contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which the diagnosis is based. *Id.* A brief and conclusory medical report that lacks supporting evidence may be discredited. *Lucostic v. United States Steel Corp.*, 8 B.L.R. 1-46 (1985); *see also, Mosely v. Peabody Coal Co.*, 769 F.2d 357 (6th Cir. 1985). Further, a medical report may be rejected as unreasoned where the physician fails to explain how his findings support his diagnosis. *Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985).

Dr. O'Bryan diagnosed no pneumoconiosis. He based his opinion on a negative chest x-ray, on physical examination findings showing overinflated lungs (which he opined was consistent with a smoking-related illness) and obesity (5'6", 248 lbs.), on a heavy smoking history, and on pulmonary function and arterial blood gas evidence which he opined showed a classic smoking-induced obstructive lung disease. Dr. O'Bryan's opinion is based on objective evidence and he documented which readings supported his diagnosis. Noting Dr. O'Bryan's credentials as a Pulmonologist, I give his opinion substantial weight.

Dr. Baker diagnosed coal workers' pneumoconiosis based on an abnormal chest x-ray and a history of coal dust exposure. In *Cornett v. Benham Coal Inc.*, 227 F.3d 569 (6th Cir. 2000), the Sixth Circuit Court of Appeals held that such bases alone do not constitute "sound" medical judgment under § 718.202(a)(4). *Id.* at 576. The Board also holds permissible the discrediting of physicians' opinions amounting to no more than x-ray reading restatements. *Worhach v. Director, OWCP*, 17 B.L.R. 1-105, 1-110 (1993) (*citing Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-113 (1989), and *Taylor v. Brown Badgett, Inc.*, 8 B.L.R. 1-405 (1985)). In *Taylor*, the Board explained that the fact

that a miner worked for a certain period of time in the coal mines "does not tend to establish that he does [or does] not have any respiratory disease arising out of coal mine employment." *Taylor*, 8 B.L.R. at 1-407. When a doctor relies solely on a chest x-ray and a coal dust exposure history, his failure to explain how the duration of a miner's coal mine employment supports his diagnosis of the presence or absence of pneumoconiosis renders his or her opinion "merely a reading of an x-ray ... and not a reasoned medical opinion." *Id.* As Dr. Baker fails to state any reason for his diagnosis of coal workers' pneumoconiosis beyond the x-ray and exposure history, I find this diagnosis neither well reasoned nor well documented.

Dr. Baker diagnosed COPD due to coal dust exposure and cigarette smoking. Such a finding, if reasoned, would conform to the legal definition of pneumoconiosis. Dr. Baker based his COPD diagnosis on pulmonary function testing. He stated that the Miner's obstructive impairment was caused primarily by cigarette smoking, but with 23 years of coal dust exposure, reported symptoms and a positive x-ray, it was his opinion that coal dust-related complications "may" be acting in synergy with cigarette-induced conditions. A physician's opinion may be given little weight if it is equivocal. *Griffith v. Director, OWCP*, 49 F.3d 184 (6th Cir. 1995) (holding that treating physician's opinion entitled to little weight where he concluded that the miner "probably" had black lung disease); *see also, Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988); *Parsons v. Black Diamond Coal Co.*, 7 B.L.R. 1-236 (1984). Dr. Baker's statement that the Miner's coal dust exposure "may" be interacting with his smoking-induced illnesses is equivocal. As such, I give little weight to Dr. Baker's diagnosis of COPD, caused in part by coal dust exposure.

Dr. Baker diagnosed bronchitis based on history. The history relied on was self-reported by the Miner. As such, it is unverified subjective and not objective evidence. Dr. Baker's physical examination of the chest was normal. As Dr. Baker offers no objective support for his diagnosis of bronchitis caused, in part, by coal dust exposure, I find this diagnosis to be inadequately supported and I give it little weight.

Dr. Houser, the Miner's treating physician, diagnosed coal workers' pneumoconiosis based on an abnormal x-ray and a history of coal dust exposure. "[T]he opinions of treating physicians are not necessarily entitled to greater weight than those of non-treating physicians in black lung litigation." *Eastover Mining Co. v. Williams*, 338 F.3d 501 (6th Cir. 2003). "[I]n black lung litigation, the opinions of treating physicians get the deference they deserve based on their power to persuade." *Id*. at 510; 20 C.F.R. § 718.104(d). "A highly qualified treating physician who has lengthy experience with a miner may deserve tremendous deference, whereas a treating physician without the right pulmonary certifications should have his opinion appropriately discounted." *Id*. In addition, appropriate weight should be given as to whether the treating physician's report is well reasoned and well documented. *See Peabody Coal Co. v. Groves*, 277 F.3d 829 (6th Cir. 2002); *McClendon v. Drummond Coal Co.*, 12 B.L.R. 2-108 (11th Cir. 1988). As discussed above, when a doctor relies solely on a

chest x-ray and a coal dust exposure history, his failure to explain how the duration of a miner's coal mine employment supports his diagnosis of the presence or absence of pneumoconiosis renders his or her opinion "merely a reading of an x-ray... and not a reasoned medical opinion." *Taylor*, 8 B.L.R. at 1-407. As Dr. Houser lists no further reasons and provides no further explanation for his diagnosis, I give his opinion less weight.

Dr. Houser also diagnosed COPD, due in part to coal dust exposure, based on pulmonary function testing. While pulmonary function testing supports a COPD diagnosis, Dr. Houser again fails to explain the basis of his coal dust etiology. As such, I give his COPD diagnosis little weight towards a finding of legal pneumoconiosis.

Dr. Repsher diagnosed no pneumoconiosis. He based his opinion on negative x-ray evidence, smoking history, pulmonary function testing showing pure obstruction, and on no histologic or arterial blood gas evidence of pneumoconiosis. He opined that while COPD could be caused by coal dust exposure, it was not detectable by objective testing and, therefore, could not be detected in any individual miner. It is proper to accord less weight to opinions that are not in accord with the prevailing view of the medical community or when a physician's testimony is affected by a subjective personal opinion about pneumoconiosis that is contrary to the congressional determinations implicit in the Act's provisions. *Blakley v. Amax Coal Co.*, 54 F.3d 1313 (7th Cir. 1995). The definition of legal pneumoconiosis specifically includes chronic obstructive pulmonary disease arising out of coal mine employment. Section 718.201(a)(2) (2001). If Dr. Repsher believes that COPD due to coal dust exposure is undetectable in any individual miner, it follows that Dr. Repsher would be incapable of making a diagnosis of COPD due to coal mine employment. I find that Dr. Repsher's opinion is not supported by sound analysis, and I give his opinion less weight on the issue of pneumoconiosis.

Dr. Simpao diagnosed coal workers' pneumoconiosis based on an abnormal x-ray, EKG, arterial blood gas and pulmonary function testing, along with physical examination findings and symptoms. A more highly qualified physician has effectively refuted Dr. Simpao's x-ray interpretation and I have found the x-ray evidence as a whole to be negative.

An opinion which fails to adequately address all possible forms of causation is undocumented, unreasoned, and of little or no probative value. *Cannelton Industries, Inc. v. Director, OWCP [Frye]*, Case No. 03-1232 (4th Cir. Apr. 5, 2004) (unpub); *Barnes v. Director*, OWCP, 19 B.L.R. 1-71 (1995). While Dr. Simpao noted the Miner's heavy smoking history, he did not discuss what impact the 70+ pack year smoking history had on his diagnosis.

A medical report may be rejected as unreasoned where the physician fails to explain how his findings support his diagnosis. *Oggero, supra.* Dr. Simpao relies on an

EKG, physical findings on examination, and symptoms, but he fails to explain how those findings support a coal dust-related disease process. I find Dr. Simpao's report to be inadequately supported and I give it less weight.

Taken as a whole, Dr. O'Bryan, a Pulmonary Specialist and B reader, provides a well-reasoned opinion, based upon objective medical evidence, that the Claimant does not suffer from pneumoconiosis as defined in § 718.201. The opinions of Drs. Baker, Houser, Repsher, and Simpao are inadequately supported and/or not well reasoned. I find that the Claimant has not established the existence of pneumoconiosis under § 718.202(a)(4).

Causal Connection between Pneumoconiosis and Coal Mine Work

Because the Claimant has not established pneumoconiosis, the question of whether it is caused by his coal mine employment is moot. The evidence necessarily fails to establish this element of the claim.

Disability Causation

Total disability has been conceded by the Employer. To establish entitlement to benefits, however, a Miner must establish that pneumoconiosis, as defined in § 718.201, is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. Section 718.204(c)(1). As the Miner has not established the existence of pneumoconiosis, he is necessarily unable to establish that pneumoconiosis was a substantially contributing cause of his disability.

VI. Entitlement

Darrell R. Curtis, the Claimant, has not established entitlement to benefits under the Act.

VII. Attorney's Fee

The award of an attorney's fee is permitted only in cases in which the claimant is found to be entitled to benefits under the Act. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for representation services rendered in pursuit of the claim.

VIII. ORDER

It is, therefore,

ORDERED that the claim of Darrell R. Curtis for benefits under the Act is hereby DENIED.

A

Robert L. Hillyard
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C., 20013-7601. A copy of a Notice of Appeal must also be served upon Donald S. Shire, Esq., 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C., 20210.